Independent Resolutions Inc.

An Independent Review Organization

Phone Number:
(682) 238-4977

835 E Lamar Blvd. 394
Arlington, TX 76011
Email:independentresolutions@irosolutions.com

Fax Number:
(817) 385-9610

Independent Resolutions Inc.

Notice of Independent Review Decision

Amended Date: **xxxx**

Case Number: **xxxxx** ***Date of Notice:*** XXXXX

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Pain Management And Emergency Medicine

Description of the service or services in dispute:

Cervical Transforaminal Epidural Steroid Injection with Fluoroscopy, a series of 2 injections at Right C4-C5 and C6-C7

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Information Provided to the IRO for Review:

Patient Clinical History (Summary)

The patient is a xxxx-year-old xxxxxxxx who reported injury on xxxxxx. The patient was diagnosed with cervical, and lumbar radiculopathy. The mechanism of injury was a motor vehicle accident. Prior treatment includes physical therapy, and NSAIDs. An MRI of the cervical spine performed on xxxxxx revealed multilevel degenerative disc changes, facet and uncovertebral arthrosis noted resulting in the C4-5 severe stenosis of the right neural foramen, C6-7 severe bilateral foraminal stenosis, mild to moderate multilevel neural foraminal stenosis, and mild central canal stenosis at C4-5, and C6-7. On xxxxxx the patient complained of back and neck pain. The patient reported his pain 9/10 on VAS in severity, as sharp, shooting, throbbing, burning, stabbing, and spasmodic quality, and non-radiating. The pain was reported as frequent.

The patient reported the pain was aggravated by walking, twisting, moving, standing, and various activities. The pain was alleviated by injections, and heating pad. The patient reported decreased function, decreased quality of life, decreased sleep, increased appetite, and decreased physical activity. The patient reported no suicidal ideation. The patient did report nausea, irritability, crying, anger, depression, anxiety, decreased sexual activity, decreased concentration, stress, and frustration. The patient had no prior history of neck or back surgery. Recent interventions included physical therapy, TENS unit, NSAIDs, chiropractic management, pain medication, and lumbar epidural steroid injections. Physical examination of the cervical spine revealed marked limitation of range of motion secondary to pain, no contractures, no crepitance, no evidence of ankylosis. No subluxations or other evidence of instability demonstrated during range of motion testing. Paraspinal muscle strength within normal limits. Paraspinal muscle tone within normal limits. Muscle bulk was normal, no signs of atrophy. No lymphadenopathy present. Spurling's test was positive. There was tingling and numbness following C5 and C7 nerve dermatome distribution.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Based on the evidence based guidelines, epidural steroid injections are not recommended for the neck, given the serious risks of the procedure in the cervical region, and the lack of quality evidence for sustained benefit. Additionally, the guidelines state an AMA review suggested that epidural steroid injections are not recommended higher than the C6-7 level. Based on the clinical notes submitted for review, the patient reported significant pain rated 9/10 on VAS in severity; however, it did not radiate. Although the patient had a positive Spurling's test, there was no evidence of decreased deep tendon reflexes including the supinator and triceps reflex. There was no evidence of weakness related to deltoid, supraspinatus, infraspinatus, triceps, wrist flexors, or finger extensors. While the MRI revealed bilateral foraminal stenosis at C4-5 and C6-7, physical exam findings did not corroborate imaging findings. There were no exceptional factors noted within the documentation which would demonstrate medical necessity for the requested treatment outside of the recommended guidelines. Given the above, the previous determination is upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor

- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)